Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 6, 2016

Ms. Nancy Peers, Manager
Brookdale At Fillmore Pond
300 Village Lane
Bennington, VT 05201-9041

Dear Ms. Peers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 2, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 08/23/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite investigation of a self-report was conducted by the Division of Licensing & Protection on 8/2-3/2016. The following regulatory deficiencies were identified as the result of the investigation:	R100	This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.	
R101 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to assure that they did not accept or retain an individual who meets level of care eligibility for nursing home admission for Resident #1 (R#1). Findings include: Per record review R#1 had a diagnosis of Dementia and a history of falls with injury. The pre-admission assessment states that the resident needs a contact guard for mobility per Physical Therapy (PT). The North Central State College PT 101 course notes defines Contact Guard Assistance (CGA) as direct contact, by a hand on the body core (not an extremity) or a device such as a gait belt, with patient for safety but with no physical assistance. With contact guard assist, the physical therapist needs to merely have one or two hands on the body or the safety device but provides no other assistance to	R101	Corrective Action: The resident no longer resides at Fillmore Pond and no other resident has PCP order or PT recommendation for contact guard. Systemic Changes: Residents who have recommendation for contact guard by their Primary Care Provider and/or Physical Therapy will be required to have 1:1 Private Duty Aide at all times. If PCP/Physical Therapy recommendation for contact guard is expected to be ongoing and family declines 1:1 Private Duty Aide at all times, resident will be given 30 day notice and Resident and family will be assisted with securing a higher level of care that is appropriate for the resident. Quality Assurance: Health and Wellness Director (HWD) or RN designee will screen all mobility orders/recommendations, ongoing. Date of completion: September 22, 2016	

R101 - R146 POCs accepted 10/6/16 mthiggins RN/PMC

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R101	Continued From page 1 perform the functional task. The contact is made to help steady the patient's body during mobility. The resident care plan includes a falls section which states that the resident is a contact guard. In an interview on 8/3/16 the Clinical Service Coordinator (CSC) confirmed that staff did not have any physical contact with the resident during mobility nor was there any specific staff designated to observe and assist mobility for this resident. Ref: www.ncstatecollege.edu	R101		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that upon a resident's admission to a residential care home, necessary services were provided or arranged to meet the resident's medical care needs. Findings include: Per record review R#1 had a diagnosis of Dementia and a history of falls with injury. R#1 was admitted after a fall at home and has four falls in June and two falls in July at the facility.	R126		

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R126	Continued From page 2 The facility has a Falls Prevention program provided by the corporate organization. This program includes a directive that falls investigations and care plan revisions after every fall would be conducted. In an interview on 8/3/16 the Heath and Wellness Director (HWD) confirmed that falls investigations and care plan revisions have not been done for R#1 or any residents of the facility on a routine basis as required by the falls program guidelines and that there were no falls assessments available for the residents reviewed, including R#1. On 7/17/16 R#1 is reported to have moved to standing position from a dining room chair, turned toward his/her walker, fell backward hitting his/her head on the floor, and sustained a significant head injury. The nearest staff member was a caregiver seated at a table with another resident. The pre-admission assessment states that the resident needs a contact guard for mobility per PT. The resident care plan includes a falls section which states that the resident is a contact guard. (See R101 for contact guard definition) In an interview on 8/3/16 the Clinical Service Coordinator (CSC) stated that the practice of staff for this resident was that when the resident was observed walking, with or without his/her walker, the staff would go to him/her and walk with her. The CSC confirmed that staff did not have any physical contact with the resident during mobility nor was there any specific staff designated to observe and assist mobility for this resident. In an interview on 8/3/16 a Licensed Practical Nurse (LPN) who works in the facility during the afternoon/evening hours stated that the resident was independent in mobility with a rolling walker. In interviews with both the CSC and the HWD acknowledged that it would be very difficult, with	R126	Corrective Action: Wellness staff will be re-inserviced by HWD or RN designee, regarding mobility assistance with contact guard. All nursing staff will be re-inserviced regarding the Fall program process. Systemic Changes: Fall program process will be completed by nurse post-fall, including investigation and development and documentation of appropriate fall intervention on the affected resident's service plan. Quality Assurance: Residents who experience falls will be reviewed monthly in Collaborative Care Review (CCR) by HWD or RN designee to verify completion of Fall Program, post-fall investigation and documentation of appropriate interventions in the resident's service plan. Date of completion: September 22, 2016	

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R126	Continued From page 3 the present staffing, to assign a staff person to assure a contact guard for all mobility for this resident.	R126		
R146 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview the facility failed to assure that all direct care personnel received instruction regarding each resident's health care needs in order to implement the care plan. Findings include: Per record review of the plan of care, R#1 requires a contact guard for mobility. (See R101 for definition of contact guard) In an interview on 8/3/16 the CSC stated that the staff walked with R#1 when they identified that s/he was walking about and observed him/her is s/he was walking steadily. In the same interview the CSC, who formulates the care plans (called service plans) at this facility confirmed that the resident's plan of care calls for a contact guard. S/he acknowledged that the practice of the staff at that time did not meet the definition of a contact guard. Per record review R#1 had a diagnosis of Dementia and a history of falls with Injury. On 7/17/16 R#1 is reported to have moved to	R146	Corrective Action: Resident no longer resides at community. Systemic changes: HWD or RN Designee will provide copy of each resident's service plan to care staff for review. New Aide Assignment plan will be utilized by each aide daily, during their shift to review care needs for each resident. Quality Assurance: During monthly Collaborative Care Reviews (CCR) HWD or nurse designee will review services provided for each resident and reassess as needed. Date of completion: September 22, 2016	

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R146	Continued From page 4 standing position from a dining room chair, turned toward his/her walker, fell backward hitting his/her head on the floor, and sustained a significant head injury.	R146		